CHESTERFIELD COUNTY, VIRGINIA
FIRE AND EMERGENCY MEDICAL SERVICES

EMS PASSP*RT

EMS PASSPORT

EMS Passport is a subscription program to help citizens defray out-of-pocket expenses, such as health insurance co-payments and deductibles, when they need emergency ambulance transportation. The Chesterfield County Department of Fire and Emergency Medical Services and the Ettrick-Matoaca Volunteer Rescue Squad charge for emergency ambulance transportation as part of the county's Revenue Recovery Program. Potential subscribers should check with their health insurance carrier to determine if **EMS Passport** is right for them.

YOU ARE ELIGIBLE

For $59 a year, a subscriber may enroll all members of his or her household. Citizens who work in, but do not reside in, Chesterfield County and students attending colleges and universities within the county are eligible to subscribe. Please note our service area is limited to Chesterfield County in most cases. An **EMS Passport** subscription is effective after the Chesterfield County Treasurer's Office receives both your payment and signed subscription form. Subscriptions are valid July 1, 2003, through Sept. 30, 2004, and are non-refundable and non-transferable.

SUBSCRIPTION PROGRAM TERMS

The annual cost for an **EMS Passport** subscription defrays out-of-pocket expenses for the uninsured portion of any charges for medically necessary emergency ambulance transportation that ends at a hospital.

An **EMS Passport** subscription covers individuals who reside at the listed address. It also includes family members who reside in assisted-living or nursing facilities located within Chesterfield County, who otherwise would be at the listed address and are on the application.

An enrollment form must be completed and submitted for processing, with your check or money order, to the Chesterfield County Treasurer's Office. You will not be able to subscribe at the time services are rendered.

HOW TO ENROLL IN THE SUBSCRIPTION PROGRAM

Complete the enclosed application (please print or type). Mail the completed application and your payment to **Treasurer, Chesterfield County, P.O. Box 70, Chesterfield, Va. 23832**. After your application is processed, your canceled check will serve as your receipt confirming your enrollment in the subscription program. For assistance, please call (804) 768-7524, or (800) 480-3625 if calling from outside the Richmond metropolitan area.

Check Number	
Date of Check	
Amount of Check	
Date application mailed	

RETAIN THIS PAGE FOR YOUR RECORDS

Names of Household Members Listed on Application	

COMPLETE BOTH SIDES OF THIS FORM **FORM 1160**

HEAD OF HOUSEHOLD			OTHER HOUSEHOLD MEMBER	
Last Name, First Name, Middle Initial			Last Name, First Name, Middle Initial	
Address			Social Security Number	
City	State	Zip Code	Date of Birth	Relationship
Phone ( )	Social Security Number		Medicare Number	
Date of Birth	Medicare Number		Insurance I.D. Number	
Name and Address for Group Insurance Policy			Name and Address for Group Insurance Policy Claim	
Insurance I.D. Number	Insurance Group Number		Insurance Group Number	

OTHER INSURANCE		OTHER INSURANCE	
If group policy, name of insurance company		If group policy, name of insurance company	
Group Number	I.D. Number	Group Number	I.D. Number
Address for Group Insurance Policy Claim		Address for Group Insurance Policy Claim	

ADDITIONAL MEMBERS RESIDING AT YOUR ADDRESS – Attach Separate Sheet if Necessary

Last Name, First Name, Middle Initial	#1		Last Name, First Name, Middle Initial	#2	
Social Security Number	Date of Birth	Relationship	Social Security Number	Date of Birth	Relationship
Insurance if Different from Head of Household			**Insurance if Different from Head of Household**		
If group policy, name of insurance company	Group I.D. Number		If group policy, name of insurance company	Group I.D. Number	
Address for Group Insurance Policy Claim			Address for Group Insurance Policy Claim		

Last Name, First Name, Middle Initial	# 3		Last Name, First Name, Middle Initial	# 4	
Social Security Number	Date of Birth	Relationship	Social Security Number	Date of Birth	Relationship
Insurance if Different from Head of Household			**Insurance if Different from Head of Household**		
If group policy, name of insurance company	Group I.D. Number		If group policy, name of insurance company	Group I.D. Number	
Address for Group Insurance Policy Claim			Address for Group Insurance Policy Claim		

Fill out this form completely. Sign the Assignment of Benefits Authorization and the Privacy Notice receipt statement. Return this form and $59 payment.

Payable to: Treasurer, Chesterfield County

Chesterfield Fire and Emergency Medical Services
P.O. Box 70
Chesterfield, Virginia 23832

Assignment of Benefits Authorization

I understand that I am financially responsible for the services provided to me by Chesterfield County Fire and EMS (CFEMS) regardless of insurance coverage. I request that payment of authorized Medicare or other insurance benefits be made on my behalf to CFEMS or its billing agent for any services provided to me by CFEMS. I authorize and direct any holder of medical information or documentation about me to release to the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration) and its carriers and agents, as well as to CFEMS and its billing agents, any information or documentation needed to determine these benefits, or benefits payable for any services provided to me by CFEMS, now or in the future. I agree to immediately remit to CFEMS any payments that I receive directly from any source for the services provided to me. A copy of this form is as valid as the original.

CFEMS is required by law to maintain the privacy of certain confidential health-care information, known as Protected Health Information, or PHI, and to provide you with a notice of our legal duties and privacy practices with respect to your PHI. You also have certain rights under federal law regarding your PHI. Our legal duties and privacy practices, and your rights regarding your PHI, are described in our Notice of Privacy Practices, a copy of which is being supplied to you.

I acknowledge that I have received a copy of the *CFEMS Notice of Privacy Practices* and authorize the assignment of benefits.

All individuals over the age of 18 who are enrolled in the EMS Passport Program must sign below.

Sign Here: _____ **Date** _____

Sign Here: _____ **Date** _____

Sign Here: _____ **Date** _____

Sign Here: _____ **Date** _____

Sign Here: _____ **Date** _____

Power of Attorney for the Individual(s) listed below:

Name of Individual (Print Name): _____

Power of Attorney (Print Name): _____

Power of Attorney (Signature): _____ **Date:** _____

Name of Individual (Print Name): _____

Power of Attorney (Print Name): _____

Power of Attorney (Signature): _____ **Date:** _____